

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037800

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9335

FILED SEP 26 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR  
TOWN ST. LOUIS

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR  
INSTITUTION 2643 CAROLINE

Inside Limits  
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE KANSAS b. COUNTY

c. CITY  
OR  
TOWN WICHITA

Inside Limits  
Yes ☒ No ☐

d. STREET  
ADDRESS 207 So MILWOOD

Reside on Farm  
Yes ☐ No ☒

3. NAME OF DECEASED  
(Type or print)

First Middle Last  
NORA MAE McCASLIN

4. DATE  
OF DEATH SEPT. 16, 1963

5. SEX  
FEMALE

6. COLOR OR RACE  
WHITE

7. Married ☐ Never Married ☐  
Widowed ☒ Divorced ☐

8. DATE OF BIRTH  
3/27/1877

9. AGE (last birthday)  
86

IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)  
HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY  
OWN HOME

11. BIRTHPLACE (City and state or country)  
KANSAS

12. CITIZEN OF WHAT COUNTRY  
U.S.A.

13a. FATHER'S NAME

WILLARD S. MARTINDALE

13b. MOTHER'S MAIDEN NAME

ELIZA BARNES

14. NAME OF HUSBAND OR WIFE

CHARLES McCASLIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, No, or unknown) (If yes, give war or dates of serv)  
No

16. SOCIAL SECURITY NO.

17. INFORMANT (SISTER) Address  
HATTIE PUTNEY 2643 CAROLINE ST.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

DUE TO

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal  
disease condition given in PART I (a)

PART III. If deceased was female was  
there a pregnancy in last 90 days.

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE  
☒ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF  
INJURY ? Hour Month, Day, Year  
a.m. 9-1-63  
p.m.

20d. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☒

20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)  
Home steps 22

20f. CITY, TOWN, OR LOCATION COUNTY STATE  
St. Louis, Mo (2643 Caroline)

21. I attended the deceased from 3:14 P. to and last saw her alive on  
Death occurred at on the date stated above, and to the best of my knowledge, from the cause stated.

22a. SIGNATURE (Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE  
9/19/1963

23c. NAME OF CEMETERY OR CREMATORY  
MOLINE CEMETERY

23d. LOCATION (City, town, or county) (State)  
MOLINE, KANSAS

24. FUNERAL DIRECTOR

ADDRESS  
E. J. SCHNUR 3125 LAFAYETTE AVE.

25. DATE RECD. BY LOCAL REG.

SEP 18 1963

26. REGISTRAR'S SIGNATURE

Earl Smith M.D.

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Stanley H. Dixon*

Licensed Embalmer No.

*4193*

P. O. Address

*St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.